Why African Countries Need to Participate in Global Health Security Discourse

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The concept of human security is increasingly accepted as being integral to contemporary notions of national security because of a growing awareness of the importance of individual and societal well-being to national, regional and global peace and stability. Health is thus considered an important component of the predominant vision of human security. However, the precise meaning and scope of global health security remains contested partly due to suspicions about clandestine motives underlying framing health as a security issue. Consequently, low and middle-income countries have not engaged global discourse on health security. This has resulted in an unbalanced global health security agenda shaped primarily by the interests of high-income countries. It narrowly focuses on a few infectious diseases, bioterrorism and marginalizes health security threats of greater relevance to low and middle-income countries. Focusing primarily on countries in the WHO-AFRO region (the African Group), this paper examines the implications of the participation deficit by the African Group of countries on their shared responsibility towards global health security. The potential benefits of regional health security cooperation are analyzed using selected critical health security threats in the Southern African Development Community (SADC). This paper concludes that the neglect of the African Group health security interests on the global health security agenda is partly due to their disengagement. Ensuring that multilateral health security cooperation includes the African Group's interests require that they participate in shaping the global health security agenda, as proposed in a putative SADC health security cooperation framework.

INTRODUCTION

Global health security considerations are increasingly shaping multilateral decisions in the global governance of health. We argue that the African Group and other low and middle-income countries (LMICs) undermine their interests by disengaging the ongoing global health security discourse, which is increasingly informing multilateral discussions in the World Health Organisation (WHO), United Nations (UN) Security Council and elsewhere. The global health security agenda reflects the national security concerns of countries and marginalises threats of relevance to countries that do not participate like the African Group, such as access to essential medicines and trade in harmful medical products. Using SADC as an example, we highlight some potential benefits of global health security cooperation to African countries and propose a possible health security cooperation mechanism within the existing regional frameworks for security cooperation.

GLOBAL PUBLIC HEALTH SECURITY POLICY

The WHO defines public health as all organized collective, public or private measures whose objective is to prevent disease, promote health and prolong the life of entire populations.[1] The concept of public health goes beyond diseases of an infectious nature. It includes non-communicable diseases, physical and mental health and policy activities at the sub-national, national, regional and global levels.[2]

Public health security is a novel concept whose precise definition remains to be clearly articulated. However, its contemporary use is generally in the context of preparedness and responses to infectious disease outbreaks and in reference to bioterrorism.[3] The 2007 WHO World Health Report defines public health security as the proactive and reactive activities needed to reduce vulnerability to acute public health events that threatens the collective health of national populations.[4] Public health security policies are thus considered as policy areas in which national security and public health concerns overlap.[5] Whilst the concept of public health which forms the basis of public health security goes beyond infectious diseases, the majority of empirical analyses on public health security describe the nature of the links between public health and national security primarily focusing on a few infectious disease threats.

Health security within countries is significantly influenced by trans-national threats from States and non-State actors alike.[6] The growing perception of the scope and significance of the external threats to national public health has led to a shift away from the concept of international health security, which applies the principles of public health to health challenges across geopolitical borders—the responses to which are primarily dependent on nation-states. The notion of global public health encompasses the entire spectrum of events with potential to undermine health worldwide. It considers sub-national, national and international threats to health codependent, thereby bringing together the mutual vulnerabilities that are influenced by trans-national determinants. It posits that effectively mitigating against such challenges requires coordinated multidisciplinary approaches by a range of actors including non-state actors. Because global public health challenges are influenced by circumstances or experiences in other countries, they are considered beyond the purview of individual countries and are best addressed through global cooperation. The transnational nature of global public health security threats and collective vulnerability underlies global public health security cooperation.

GLOBAL PUBLIC HEALTH SECURITY AGENDA

The WHO, the global convener and norm-setting health agency of the UN uses the global health security agenda to coordinate health cooperation amongst the global community. This agenda currently narrowly focuses on a few infectious diseases and bioterrorism,[7] neglecting other health issues that also undermine individual and societal health security of populations in LMICs, such as lack of access to life saving essential medicines and vaccines. This focus on infectious diseases and bioterrorism in global health security discourse reflects the national concerns of countries actively involved in shaping the global health security agenda. For example, the U.S. government's Public Health Security and Bioterrorism Preparedness and Response Act of 2002 articulates the national need to combat threats to public health, focusing on threats from

bioterrorism.

The paucity of diverse voices shaping the global health security agenda has led to the neglect of equally important health security threats of relevance to African countries and LMICs. This paper explores some of the health security threats of relevance to LMICs in the WHO-AFRO regional context which excludes North African countries. It examines why African countries and other LMICs do not engage the global health security policy discourse, the impact of their disengagement and possible mechanisms through which they could circumvent possible limitations to their participation in order to advance their health security interests in multilateral cooperation.

HUMAN SECURITY: A NOVEL SECURITY PARADIGM

The concept of international health security stretches back to 1947 when the State Department of the U.S. used it in their analysis of the pre-World War II International Sanitary Conventions.[8] Its contemporary use is associated with human security, a novel security concept that considers national security to be more than the military defense of a state's territory and sovereignty.[9] The defense of a country's territory and its sovereignty from foreign threats is traditionally considered the primary objective of foreign policy and a state's highest priority. This view of national security was the basis of the cold war concept of security, which focused solely on securing the vital national interests of countries through foreign policy or against external threats of a military or forceful nature. A security threat was understood then to be any event, incident or process that could compromise the protection of a state's integrity and political autonomy from potential harm.[10]

However, the end of the Cold War altered the prominence of military threats, thereby eroding this traditional concept of national security and led to the recognition that exclusive focus on state security had become obsolete. Thus, a new security paradigm which incorporates human security as an important component of national security was conceived. The expansion on the conventional military definition of threats to include direct and indirect threats to the well-being of individuals and societies within countries to include health makes human security a major departure from the traditional concept of security. Human security as an objective of national security is based on the premise that the provision of basic needs of individuals and societies is important for maintaining national and international peace and stability.

HUMAN SECURITY IN INTERNATIONAL POLICY-MAKING

A cacophony of voices including governments, scholars and practitioners has provided diverse interpretation and meaning of human security. It is, however, generally understood to be principally about protecting and empowering people.[11] The UN Commission on Human Security defines human security as the protection of "the vital core of all human lives."[12] The UN Security Council and UN Development Programme's (UNDP) definition of human security considers health as an important element of human security.[13] Therefore, this paper utilizes human security in its original broad meaning as defined by UNDP.

The concept is widely accepted within the UN system, as suggested by the establishment of a Commission on Human Security and the convening of the UN World

Summit in 2005 to determine ways of achieving human security. The Commission's report, Human Security Now, considers human security as complementary to state security, and recommends access to basic health care as an important element.[14]

The WHO's World Health Report of 2007 deviates from the broader interpretation of the concept shared by the Commission and other UN institutions such as UNDP and the United Nations International Children's Emergency Fund (UNICEF). It focuses on specific issues that threaten population health internationally and on global compliance with the International Health Regulations as revised in 2005 (IHR2005).[15] The WHO links health security to infectious diseases. It subsequently renamed its communicable diseases cluster to Health Security and the Environment, but has not defined the scope of health security or its implementation.[16] The WHO's limited use of the concept is symptomatic of the concept's rejection by its Member States.

Beyond the UN, a limited number of governments have integrated human security and its focus on the security of individuals rather than states into their foreign policies. For example, in keeping with the UN Charter's emphasis on preventive diplomacy to mitigate against threats escalating into crisis, Japanese[17] and Canadian[18] foreign policies are informed by human security. Human security has also informed international legal instruments such as the 1997 Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction, and the Rome Statute of the International Criminal Court.[19]

ORIGINS OF HUMAN SECURITY

Human security has its roots in the UN Charter of 1945, which considered the achievement of peace to be contingent upon freedom from fear and the socioeconomic objective of freedom from want.[20] The rationale was that world peace could only be achieved if people have security in their lives. Since then, the UN alluded to human security in the 1992 document 'An agenda for Peace'[21] and explicitly mentions it in the 1994 UNDP Human Development Report: New Dimensions of Human Security[22] which aims to promote social development and achieve peace through investment in human development. Its inception was an attempt to remedy the historical Cold War neglect of the concerns of citizens in national security. UNDP considered this approach to national security important because contemporary causes of conflict were increasingly arising from within rather than from outside states.

People are primarily concerned with protection from the threat of diseases, political repression, violence, crime and social conflict, amongst others. Therefore, their perceptions of threats to their individual security reduce their tolerance. This is highlighted by the increase in anti-immigration sentiments and the rise of the far rights groups across Europe associated with the economic downturn. These perceived threats to individual security can create a destabilizing force within nations and beyond. Human security thus promotes an approach to national security which considers protecting citizens' security within countries, against both internal and external threats to their health and well-being alongside other interests of the state. Protecting the entirety of nations' security requires mitigating against threats of any type or origin, to the vital core of people's lives to achieve freedom from want and freedom from fear for individuals and societies.[23]

FREEDOM FROM WANT AND FEAR FROM A PUBLIC HEALTH PERSPECTIVE

From a public health perspective, freedom from want involves protecting individuals from diseases, ensuring their access to health care and access to essential life-saving medicines. [24] Freedom from fear entails protecting individuals from threats of a violent nature stemming from conflict and disaster and emergency situations, with potential to inflict physical harm.[25] The objective of both freedoms and of the shared responsibility towards health security is to ensure that social, political, economic and environmental determinants do not undermine people's health and wellbeing.

Therefore, actions or events that could undermine the quality of life of a country's citizens or threaten to significantly reduce its public and private policy options in contemporary society are considered national security threats. For example, 9/11 and the subsequent anthrax attacks undermined the individual and society's ability to live free from fear, and thus affected their human and health security. Similarly, efforts by the European Union (EU) and the U.S. to enforce TRIPS-Plus conditions (a principle involving Trade-Related Aspects of Intellectual Property Rights among and/or involving WTO members that can create higher standards)[26] in bilateral Free-Trade Agreements (FTAs) that seek to limit LMIC's legislative and policy-options to enable access to life-saving essential medicines constitute a health security threat. Therefore, measures to protect global health security should include interventions that protect individuals and societies from diverse threats.

Such threats include trade in harmful medical products, also called "substandard/spurious/falsified/falsely-labeled/counterfeited" medical products, lack of access to life-saving essential medicines, lack of access to health care, antimicrobial drug resistance, emerging and re-emerging infectious diseases, national disasters such as the recent Asian Tsunami or the earthquake in Japan, humanitarian crisis arising from conflict such as in Libya, chemical accidents such as Bhopal in India, and deliberate attacks on health such as the U.S. anthrax attacks.[27] Yet many of these threats including lack of access to lifesaving medicines or trade in harmful medical products are absent from the global health security agenda. Their absence is an unfortunate omission that needs to be remedied. Such remedial action is necessary because in its original scope, human security is considered universal, its components interdependent, people-centered and easier to promote through preventive measures.

HEALTH SECURITY CODEPENDENCE

National health security emergencies, especially those arising from infectious diseases such as severe acute respiratory syndrome (SARS), can escalate into regional and international crises with global repercussions on public health, international trade and commerce.[28] This illustrates the codependence of national and global health security as a result of a myriad of globalization processes and the concomitant increased interaction between them. For example, the interaction between global trade and commerce, human mobility, climate change and disease[29] has increased the potential for health security to undermine trade, tourism and access to goods (such as medicines) and for health security to be undermined by them.

For instance, the growing incidence of emerging disease and re-emerging infectious diseases[30] is fueled by processes such as urbanization and climate change in

the context of increased human transnational mobility. From 1996 to 2004, the WHO identified an emerging infectious disease in each of its six regions, including SARS coronavirus in China, Nile Fever in the U.S., and new variant Creutzfedt-Jacob's disease in Europe. The spread of antimicrobial resistance genes such as the New Delhi-Metallo-β-lactamase 1 (NDM-1) identified in 11 bacteria species including those causing cholera and dysentery and multiple drug resistant tuberculosis constitute a serious emerging threat to health.[31] Diseases once thought to be under control but are re-emerging influenced by a myriad of factors such as shifting attitudes toward vaccination, irrational use of drugs, climate change, trade in harmful medical products and human mobility include the ongoing measles outbreaks in France, Turkey and Spain, polio in Pakistan and Nigeria, yellow fever in West Africa and Marburg haemorrhagic fever in Angola. The potential for disease amplification and spill-over across international borders has thus grown considerably.

OUR SHARED RESPONSIBILITY, THEIR HEALTH SECURITY?

Codependence coupled to the increased diversity of health threats has raised the geopolitical importance of global health security and the need for multilateral cooperation to protect health. Because global health security is as strong as its weakest link, the UN Secretary General called health security and the vision for a more secure global society a "shared responsibility."[32] However, whether multilateralism translates to improved health security for all remains questionable. Empirical evidence does not suggest that the framing of global health security in terms of common vulnerabilities leads to better health security in African and other LMICs.[33]

Recent civil unrest in North African countries like Egypt, Libya and in the Middle East in early 2011 lends credence to the idea that unmet needs of individuals and societies can destabilize national-regional and, therefore, global peace. Furthermore, responses to this civil unrest as seen in Libya and Syria in April 2011 demonstrate that governments can and do pose a threat to the human security of their own citizens. Resultant instability has far-reaching consequences. For example, the influx of 25,000 people fleeing such revolutions in North Africa in Italy and France has prompted these countries and the EU to explore possible regulation of passport-free travel within the Schengen zone. Therefore, the importance of individual and societal security to maintaining national and international peace and stability renders national security and stability an international concern and hence a shared responsibility. Shared responsibility towards mitigating health security threats and other threats to human security within countries is underpinned by enlightened self-interest.

Shared responsibility arises from the need to maintain the integrity of the global system, a critical concern for wealthy nations. For this reason, health security issues that potentially threaten the integrity of the international system such as the H1N1 pandemic influenza, H5N1, and other influenza viruses with pandemic potential, form the focal point of contemporary health security concerns alongside bio-weapons.[34] The recent conclusion of the intergovernmental negotiations on the framework for pandemic influenza preparedness by WHO Member States on the 16th of April 2011 highlights the importance of this issue to the global community. Among other things, the framework addresses the issue of inadequate global production of antivirals and influenza vaccines to expedite their accessibility to LMIC populations based on public health risk and need.

In contrast to the historical neglect of product development for many diseases that threaten the health security of people in LMICs,[35] this triumph of multilateralism to ensure global health security, suggests selective shared responsibility.

A similar show of global solidarity has not occurred with some significant threats to health of relatively less concern regarding their potential impact on the international system. For example, despite that 9 million people develop active tuberculosis (TB) each year, there have been virtually no newly licensed TB drugs in 40 years, and an effective vaccine remains elusive despite enormous strides in bio-molecular technology. This paucity of effective diagnostics and therapeutics for TB and other neglected diseases primarily results from underinvestment in research for these health threats. Yet a multilateral solution to the challenge of scaling up and expediting access to influenza antivirals and vaccines has been found relatively quickly. This suggests that lack of political will to find sustainable solutions to some health challenges makes shared responsibility a hollow promise.

Even with health security threats where multilateral cooperation is recognized as being essential to mitigating them such as the threat of bioterrorism, shared responsibility still does not entail protection in LMICs. For example, in the event of a bioterrorist attack with smallpox or anthrax, insufficient global pharmaceutical manufacturing capacity for vaccines and antibiotics against these threats is likely to limit access and therefore the security of LMIC populations. For example, there is currently no medico-scientific capacity to diagnose smallpox in the entire African region. Diagnostic capacity is concentrated in the North, in the U.S, the Russian Federation and Europe. Therefore, our shared responsibilities to ensure health security offer little, if any, protection for LMIC nationals.

THE LOGIC OF SECURITISING HEALTH

Whilst shared responsibility may not entail shared benefits, the logic of security is useful in influencing political debate on issues such as global health. Securitization is the identification of an existing threat that takes an issue beyond the usual rules of politics, and calls for urgent and extreme measures to respond. Thus portraying health as a security concern (securitization) is a valuable mobilization tool in that it links domestic and external threats to health. This allows national threats to be projected in an international context such that the threats can be viewed as issues of global concern thereby increasing the impetus for multilateral cooperation. For example, HIV/AIDS, the first health problem addressed by the UN Security Council, was declared a security threat in 2000.[36] This led to a subsequent increase in its political prioritization which culminated in efforts to establish the Global Fund to Fight AIDS, Tuberculosis and Malaria and increased health development financing between 2000 and 2005.[37]

Similarly, prior to H5N1 avian influenza, aid for international influenza surveillance, pandemic planning and response was virtually nonexistent. The securitization of pandemic influenza spurred a dramatic increase in the amount of funding available for international surveillance, pandemic planning and responses. In the United Kingdom (UK) between 2004 and 2008, over $2 billion was made available[38] and according to the Centers for Disease Control and Prevention, the annual expenditure on influenza in the U.S. averages $17 billion compared to $720 million for hepatitis B or $7 billion for sexually transmitted diseases excluding HIV. Therefore,

conceptualizing health as a security challenge is persuasive towards increasing the political prioritization of health in geopolitics, increasing funding for health issues and strengthening global cooperation to protect public health.[39]

SECURITIZATION AS A RATIONALE FOR HEALTH FOREIGN POLICY

The securitization of health partly accounts for the growing trend of crafting health foreign policies by wealthy countries such as the U.S., the UK and Switzerland. Specific events such as the global pandemic influenza, fears of bioterrorism and of emerging and resurgent diseases have strengthened the perception of health as an important element of national security[40] and its acceptance as a foreign policy issue. The Oslo Group of 7 and the subsequent UN General Assembly resolutions A/Res/63/33 and A/64/L16 urge countries to consider health issues in their foreign policies.[41] It promotes health as an important foreign policy goal in itself.[42]

If the rationale for health foreign policy and bilateral or multilateral cooperation is the protection of the health security of nationals, it follows that countries may act to protect their interests by omitting health security threats with little relevance to their national health security concerns. Therefore, arguments that health in foreign policy allows foreign policy to move away from debates about interests to one about altruism[43] do not reflect the basic premise of foreign policy. Foreign policy health initiatives are primarily a major tool for improving national security, projecting power and influence, improving countries' international image and for supporting other traditional foreign policy objectives.[44] This precludes the interactions of health and foreign policy from being necessarily mutually reinforcing or mutually beneficial.[45]

Since the global health security agenda is driven by foreign policy interests of its architects, global health political priority threats in multilateral cooperation fora omits major health security concerns of LMICs. Similarly, because health development assistance is principally driven by foreign policy considerations, it is generally guided by the interests of benefactors rather than by national health security priorities of development partners.[46] Consequently, the use of health initiatives as instruments to advance foreign policy interests in bilateral and multilateral cooperation often leads to the underfunding of key health security priorities and the misalignment of global health priorities determined by the World Health Assembly, budgetary allocations and program funding.

Therefore, assumptions based on available evidence, that the benefits of health to foreign policy are so great that health substantially drives foreign policy[47] have little if any relevance to LMICs. Whilst benefits do accrue from health foreign policy activities in LMICs, their grounding in national interests of development partners suggests their benefits may equally be limited. This limitation is exacerbated by power imbalances characteristic of bilateral and multilateral negotiations which restricts the extent to which LMICs can negotiate agreements better aligned with their own national health security concerns. The recent smallpox negotiations during the 64th WHA when the US threatened to force a vote on postponing setting a date for the destruction of the remaining variola virus stocks to bypass objections and the EU and the U.S. efforts to enforce TRIPS-Plus conditions in FTAs with LMICs are a case in point. Coercion undermines confidence, generates resentment and suspicions about ulterior motives which can undermine global health security cooperation.

THE DEFICIENCIES OF SECURITISATION

Securitization as a rationale for linking foreign policy to health is criticized for introducing great power politics and narrow national security interests into health and humanitarian matters[48]. It has led to the narrow framing of health security and the dominance of foreign policy considerations over global public health. Treating global health issues as national security threats also focuses disproportionate attention on diseases and countries considered to pose a threat to wealthy nations rather than the greatest threat to global public health.[49] For example, whilst evidence used to support the securitization of HIV and AIDS was subsequently shown to be false, securitization was used as a justification for implementing HIV-based travel, migration and entry restriction policies and legislation that barred entry of people living with HIV into countries such as the U.S., Canada and China. [50] Whilst China and the U.S. recently repealed this legislation, similar restrictions are still widely enforced in many countries such as Russia.

Furthermore, the securitization of public health and the use of public health security as a tool to fight terror have led to greater investment in counter-bioterrorism and less investment in essential public health functions such as routine immunizations.[51] Securitization also raises questions about motives and has generated growing suspicions amongst LMICs[52] as suggested by the controversies over the sharing of H5N1 pandemic influenza viruses and benefit sharing and within IHR(2005) negotiations.[53] The results appear designed to protect the health security of wealthy countries from emerging and resurgent infectious disease threats. That epidemiological intelligence gathered in LMICs seems to primarily benefit wealthy countries suggests this. During the recent revision of WHO IHR(2005), the U.S. insistence that mandatory entry into affected countries be authorized to allow bypassing a country's consent[54] in circumstances where its efforts to control an epidemic are considered inadequate to prevent international spread by other countries, generated further reservations on securitization. The U.S. proposal was rejected by the majority of Member States because of its potential to violate their sovereignty.

Questions regarding the motives of health securitization have led to its rejection by LMICs. For example, during the WHO Intergovernmental Working Group (IGWG) on pandemic influenza preparedness and the sharing of benefits in November 2007, Portugal attempted to introduce the term global health security in a draft statement.[55] Portugal asserted that global health security should have preeminence over other laws.[56] This proposal was categorically rejected by Indonesia, Thailand, India and Brazil.[57] The concept was similarly challenged by Brazil during the 2008 WHO Executive Board during discussions on the implementation of IHRs because there is no clear meaning of the term and it is not supported by the Assembly: Brazil pointed out the lack of clarity on the goal of international health security and the need for Member States to work on a consensus definition.[58] However, whilst the word "security" was not used in the revised regulations (except in reference to a World Health Assembly resolution) the WHO Secretariat subsequently introduced it in its report which described the IHR(2005) as an important instrument for ensuring that the goal of public health security is fully met.

PREFERENCE FOR BILATERALISM OR MULTILATERALISM

The need to protect health security has increased its acceptance as a legitimate foreign policy concern in Western countries. Countries with health foreign policies are mainly in Europe and North America. For example, the UK[59], U.S.[60] and Switzerland[61] project their national health security concerns through their health foreign policies which guide their bilateral and multilateral activities in the governance of global health.[62] Whilst health foreign policy is commonly professed to have altruistic objectives such as the protection of the poor and people in failed States,[63] a more probable driver of health foreign policy is the need for protection from bioterrorism, the global spread of diseases and their impact on the global economy. The increasing preference for health foreign policy may be because bilateral negotiations allow countries to go beyond international law in order to protect their national health security.

Furthermore, the ascendance of non-military power has resulted in the gradual diffusion of power to a broader range of state and non-state actors such that power is no longer concentrated in the hands of a few. High economic growth rates in emerging countries such as Brazil, Russia, India and China (BRICs) have increased their political influence in global governance of health and other sectors such as trade. Their political willingness to challenge the traditional powers on matters of national interest has created a balancing effect as illustrated by Brazil's successful challenge of the TRIPS regime.

This has transformed health geopolitics by altering the dynamics of multilateral negotiations and the importance of soft power to influence international health politics. Soft power is a diplomatic approach to obtain foreign policy objectives through persuasion and collaboration rather than through economic influence or political domination. Examples of recent breakthroughs that curtail the interests of traditional powers are the 2010 WHO Global Code for the International Recruitment of Health Personnel (WHO Global Code) and the recently concluded pandemic influenza framework.[64] Whilst these changes do not mean power asymmetries no longer exist, they are important steps in transforming the multilateral system by limiting the ability of the traditional powers to impose their policy will within multilateral institutions. This may partly explain the increasing preference for health foreign policy, which may be an attempt to circumvent the diminishing power in multilateral fora.

However, not all countries have crafted health foreign policies. There is no known documented foreign policy approach for Senegal and South Africa, the two African countries which participated in the introduction of health as a foreign policy in the UN. And others have taken a different approach to health foreign policy. For example, Brazil emphasizes south-south cooperation whilst Thailand focuses on regional cooperation. Greater cooperation between LMICs and emerging economies like the BRICs has increased their bargaining power in multilateral negotiations and is successfully offsetting power asymmetries in the global governance of health. These countries therefore show a greater preference for multilateralism though they have not adopted explicit health foreign policies. A dichotomy of preferences therefore emerges. The North's fear-driven dual approach to national health security employs health foreign policy in bilateral relations to reinforce the less than optimal multilateral solutions. The South's growing confidence and suspicions of the North's motives show a preference for regional cooperation through like-minded coalitions.

ENSURING GLOBAL HEALTH SECURITY FOR ALL

Ensuring global health security for all requires a balanced and inclusive agenda. This can only occur if LMICs participate in shaping the global health security agenda in order to determine how it can better serve their domestic health security needs. Furthermore, since there is no consensus on the meaning of global health security, participation would enable LMICs to provide their understanding of what global health security should entail and broaden its scope beyond its current narrow definition.

The African Group and other LMICs are affected by the health security issues that are marginalized on the global health security agenda such as lack of access to life-saving medicines and health workforce shortages. The majority of empirical analysis characterizing the interaction between health security and health foreign policy has been made from a high-income country perspective. There is little if any analysis of this interaction in the LMIC context. This limits the relevance and applicability if any of such generalizations to LMICs. The inherent nature of foreign policy as a function of national interest whose primary objective is to protect national security, economic interests and national development precludes health foreign policy from serving altruistic purposes it is alleged to serve. Its primary purpose as the pursuit of self-interest is a goal that potentially undermines solutions that respond to the threats of greater relevance to LMICs.

For example, Laos receives disproportionate donor support in influenza surveillance from several sources including the US Navy EWORS and the Rockefeller Foundation-funded Mekong Basin Disease Surveillance Network. [65] However, whilst surveillance data is of great value by providing early warning to other countries of possible international spread of diseases, it has limited practical value to the country originating the data if the country has limited health systems capabilities. Functioning health systems are the bedrock of any credible responses to health security threats. Therefore, effective disaster responses including the containment of disease outbreaks requires viable health systems,[66] and investment in basic health services to ensure broader and sustainable health security responses that are capable of addressing a variety of potential health security threats.

Therefore, global commitment to build sustainable responses to security threats should not be limited to surveillance and containment, but need to integrate health systems strengthening. Though developing, strengthening and maintaining health systems is more costly than introducing infectious disease surveillance and outbreak containment, such an approach would ensure that poor countries also benefit from timely and open sharing of epidemiological intelligence essential for protecting global health security.

POSSIBLE LIMITATIONS TO PARTICIPATION BY AFRICAN COUNTRIES

The African Group and other LMICs face unique health security threats that are not congruent with the narrow focus of the global health security agenda, yet seriously undermine their national health security. The lack of engagement of health security discourse by African countries may be a manifestation of their rejection of this concept as a rationale for multilateral action. For example, the African Group supported Brazil,

India, Thailand and Indonesia's, objection to the concept of global health security during pandemic influenza and International Health Regulations negotiations. [67]

However, effective participation must begin with a clear articulation of national health security threats within African countries. Identified priorities should inform their foreign policy interactions in bilateral and multilateral cooperation. This requires coordination of all relevant stakeholders to determine priority threats and to achieve national policy coherence at the intersection of health and other cross-cutting issues relevant to other government ministries, including foreign affairs, trade, development and defense. Effective coordination is a resource-intensive process. This limitation could be circumvented by pooling resources such that the health security threats of African countries are considered within regional configurations.

Another possible limitation to African country participation may be that coercion by wealthy countries has espoused a culture of being passive recipients of high-income country policy initiatives such as the health foreign policies shaping the global health security agenda in the WHO, the UN General Assembly, the UN Security Council and in bilateral cooperation. For example, the U.S. has threatened sanctions on countries that attempt to utilize TRIPS flexibilities and pressured them to implement TRIPS-Plus provisions, which undermine access to affordable medicines.[68] The U.S. disregard of the health priorities and needs of African may also explain their hesitation in engaging global health security policies.

THE MERITS OF ENGAGING GLOBAL HEALTH SECURITY DISCOURSE

Whilst LMICs might reject explicit reference to health security in multilateral agreements such as the IHR(2005), the concept is progressively influencing multilateral decisions despite perceived legitimacy and merits of LMICs reservations. For example, subsequent WHO reports to the Executive Board described IHR(2005) as an important instrument for protecting international public health security.[69] Furthermore, during the April 2011 intergovernmental pandemic influenza preparedness negotiations, some Member States including Norway, stressed the need to finalize the pandemic influenza preparedness framework in order to ensure global health security. More importantly, a recently proposed resolution at the 64th WHA on the destruction of the remaining stocks of variola virus stocks used the need to protect global health security from the threat of bioterrorism with reconstituted genetically-engineered weaponised smallpox as a justification for maintaining the viral stocks at the repositories in the US and the Russian Federation. This sequence of events suggest that in the long term, LMIC neglect of this discussion may be detrimental to their health security interests because global health security discourse continues with or without their input and the outcomes influence multilateral decisions in subtle but incrementally significant ways.

Countries not engaging health security discourse at national level are limited in their ability to elaborate their national health security priorities or to inform their multilateral and bilateral negotiation positions with such priorities. The potential for global health security cooperation to translate to positive health outcomes for African country health security priorities is contingent upon their ability to engage global health security discourse to ensure better representation of their national-regional health security concerns. A proactive approach could prevent the marginalization of their health security threats and bring the required balance to the global health security

agenda.

Whether African countries and other LMICs accept or reject the securitization of health, their multilateral obligations means that they remain key stakeholders in the implementation of a global health security agenda that does not serve their health security interests. Therefore, they need to carefully weigh the potential benefits of engaging against their current approach of disengagement. Joint problem-solving, proposal and collaboration on innovative policy interventions would ensure a more inclusive agenda and prevent a shared responsibility towards the health security concerns of others. Furthermore, greater engagement could provide impetus for African countries to develop more coherent national health strategies underpinned by their health security interests.

BRINGING HEALTH SECURITY TO THE AGENDAS OF AFRICAN COUNTRIES

Passive reliance on other countries' health foreign policies undermines the health security needs of African countries. For example, health foreign policies of these countries can have ideological conditions harmful to health. PEPFAR, implemented in 15 countries, several in Southern Africa, such as Zimbabwe, Botswana and South Africa, required 33 percent of funds to be earmarked for programs promoting abstinence until marriage. This was widely criticized for undermining proven public health interventions[70] by neglecting risk reduction measures based on public health principles. Its top-down, vertical approach undermined national programmatic knowledge and neglected health systems and sexual health.

Cooperation on health security amongst African countries could provide greater bargaining power to negotiate bilateral agreements better aligned with public health principles. It could also positively influence outcomes in multilateral negotiations that affect African health security, such as climate change which affects food security and trade agreements that affect access to essential medicines.

African countries could follow good policy practices. For example, Brazil successfully leverages its advocacy for access to antiretroviral medicines for people living with HIV and AIDS[71] into expanded south-south cooperation, leadership, diplomatic influence and access to markets.[72] These activities have raised Brazil's international standing thereby promoting its foreign policy goal to obtain a seat in the UN Security Council. China similarly leverages its support for health programs in African countries to support its foreign policy objective to gain access to strategic resources and markets in African countries. For example amongst its numerous health promoting foreign policy initiatives, in early 2011, China announced a bilateral agreement deal with Zimbabwe of $585 million to boost health and agriculture sectors.[73]

Global economic growth projections by the World Bank that the African continent will have the second highest annual economic growth rate next to Asia in 2011[74] should inspire African countries to become more assertive in advocating for a balanced global health security agenda that also mitigates their health security concerns. African countries could consider leveraging access to their resources through health foreign policies to ensure that bilateral and multilateral agreements with development partners like China, the U.S. and the UK do not undermine health security within their countries. In a contemporary global society where countries routinely use health as a bargaining chip in bilateral and multilateral negotiations and use health interventions to

achieve strategic foreign policy objectives, African countries could benefit from a better understanding of how they could better leverage their resources and strategic health foreign policy interests to promote national and regional health security as routinely done by other countries.

AFRICAN REGIONAL HEALTH SECURITY COOPERATION FRAMEWORKS

Whilst there are no documented discussions on health security in the context of health foreign policy in most African countries, health has long been on African regional agendas. Various fora exist through which health security issues could be integrated without needing novel structures to act as a vehicle. These could provide a platform for systematic analysis to determine health security priorities that require foreign policy action in African countries. African health security cooperation frameworks established within such pre-existing regional cooperation structures such as the SADC community could be implemented under existing international legal instruments such as the IHR(2005) or the WHO Global Code, which African countries are already under international legal obligation to implement in their own countries.

The 15 Member State economic integration partnership of SADC has a mission to promote socio-economic development, peace and security through deeper integration and cooperation.[75] Representing a total population of 170 million people, SADC FTAs create a regional market worth $360 billion and include economies with annual growth rates of over 7 percent. The SADC community already possesses a suitable institutional framework that could adopt the concept of health security and expand it beyond SADC's current exclusive focus on HIV and AIDS to recognize a myriad of other threats to health in the region some of which are briefly discussed below.

The putative SADC health security cooperation framework could be embedded within the existing organ on politics, defence and security cooperation. Incorporating health security as a component of security cooperation under the existing SADC security cooperation organ could enhance the appeal of the concept with its Member States. It may also be an innovative way of improving the chronically underfunded health sector through linkage with better-funded national security budgets on the basis of health being a national security issue. This health security cooperation framework could guide and inform national health foreign policies within SADC countries. Should a common health security cooperation framework not prove feasible, an alternative approach could be to increase national and regional policy coherence on foreign policy and health without formal strategies as has been done by some countries in the Oslo Group of Seven such as Thailand, Brazil and Indonesia.[76]

However, whilst informal cooperation may work in the context of individual country approaches, it may not provide an effective model for partnership across many countries by failuring to command their commitment thereby undermining cooperation. Therefore, a formal regional health security cooperation framework might provide a better model for regional health security cooperation for SADC or other African regional groupings. SADC health security priorities could guide national legislation, foreign policies and be harmonized with the priorities of other African regions to provide a wider platform for the African Group strategy in multilateral cooperation.

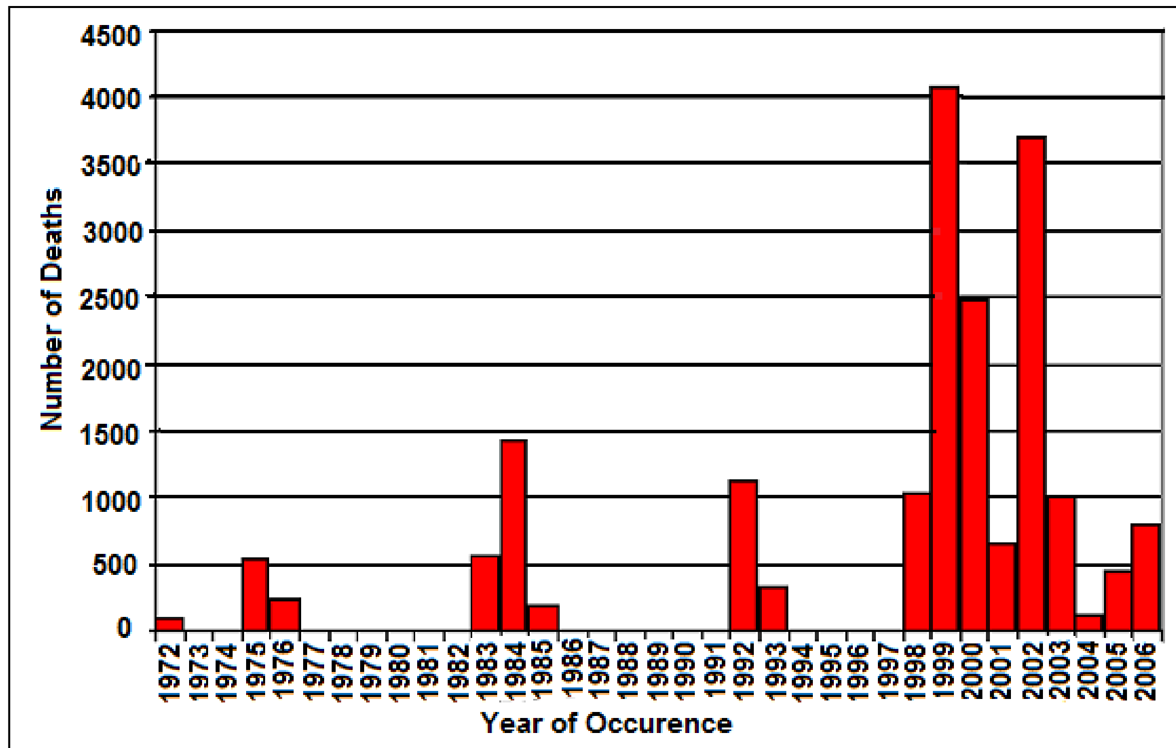
SADC Health Security Codependence

The 2008 Zimbabwe cholera epidemic illustrates health security codependence amongst SADC countries and supports the benefits of health security cooperation in the region by illustrating how cooperation could mitigate similar regional health security challenges. Cholera is an acute intestinal infection caused by the consumption of food and water contaminated with the bacterium, *Vibrio cholera*, which manifests itself as a diarrheal sickness.[77] The provision of safe drinking water, adequate sanitation and food safety are critical to preventing and reducing the spread of cholera. Public health messages to enhance communities' preventive behavior to halt further contamination and infection are equally important. Whist interventions to mitigate cholera spread are relatively simple and cheap; they are dependent upon functional health systems, effective surveillance, early detection and rapid response mechanisms.

In 2007, the health system of one of the SADC community countries, Zimbabwe, was severely debilitated by the social, economic, and political crisis that embroiled the country. Rampant inflation and economic free-fall put the government under enormous financial stress. Negative ramifications were felt in all sectors of society with health being one of the worst affected. Resultant massive cuts in national health expenditure coupled to social policies that undermined population housing conditions, the availability of safe drinking water and adequate sanitation were a prelude to the health security crisis. The government struggled to pay health personnel and other civil servants. These factors partly accounted for the massive exodus of people including health personnel into neighboring countries.

Incapacitated health systems severely undermined response capabilities to the impending cholera epidemic whose onset occurred in August 2008. Ordinarily, based on prior history of low frequency sporadic cholera cases occurring in Zimbabwe since 1972, Figure 1[78] this might have resulted in better preparedness and rapid responses at the epidemic onset. However, the ongoing crisis severely curtailed early detection and responses. The consequent delayed response allowed dramatic deterioration of the national crisis before concerted responses could be initiated. With the declaration of a national emergency situation occurring five months after the epidemic onset, Zimbabwe's national health systems were under severe pressure and its capabilities overwhelmed.

Figure 1: Cholera in Zimbabwe, 1972 – 2006



Source: Zimbabwe Ministry of Health and Child Welfare

The concomitant exodus of people into neighboring countries allowed cholera spillover into the entire SADC region. The evolution of this epidemic demonstrates national-regional health security connection resulting from intra-regional human mobility and the trade routes linking all SADC countries. SADC did not have an appropriate response mechanism to mitigate the spread of the epidemic into the entire SADC community, and the IHR(2005) advises against quarantine measures, trade and human embargoes because they are ineffective at controlling the trans-national spread of cholera. A SADC health security cooperation framework guided by this instrument might have facilitated innovative ways of mitigating a regional crisis.

The Zimbabwean Ministry of Health and Child Welfare, in collaboration with local and international partners, launched coordinated responses, providing safe drinking water, disseminating health information and rehydration therapy to those affected subsequently halting the epidemic. Across countries, differences in reported cases, case fatality rates and the total number of deaths as shown in Table 1, illustrates the different response capacities within countries. Countries without a concurrent internal crisis whose health systems were not under severe stress such as Botswana (2 deaths) and Namibia (9 deaths) had fewer cases, lower case fatality rates and total recorded deaths.

Table 1: Cholera Deaths in SADC 2008-2009 Cholera Season.

Country	**Reported Cases**	**Reported Deaths**	**Case Fatality Rate**	**Time Period**
Zimbabwe	98, 349	4,276	4.4%	15 Aug 2008-24 May 2009
Mozambique	17, 761	140	0.8%	1 Jan 2009-9 May 2009
Swaziland	17, 448	0	0.00%	22 Dec 2008-16 May 2009
South Africa	12, 752	65	0.5%	15 Nov 2008-31 May 2009
Zambia	8, 312	173	2.1%	10 Sept 2008-7 May 2009
Angola	7, 495	134	1.8%	1 Jan 2008-17 May 2009
Malawi	5, 269	113	2.1%	15 Nov 2008-24 May 2009
Namibia	203	9	4.4%	22 Oct 2008-17 Apr 2009
Botswana	15	2	13.3%	1 Nov 2008-24 May 2009
TOTAL	**167, 604**	**4,912**		

Source: United Nations Office for the Coordination of Humanitarian Affairs Regional Update

Partnership and cooperation are of greater importance in national contexts where health systems capabilities are limited because they leverage national health security needs to create synergistic responses to regional health security threats, facilitate early detection and expedite responses, thereby mitigating the potential impact of threats to the entire region. This case illustrates SADC health security challenges such as weak surveillance and poor emergency preparedness and the lack of credible mechanisms for limiting the impact of policy actions outside the health sector such as water and sanitation policies and poor social protection from severely undermining health security of countries and the region. It also underscores the cross-sectoral nature of health threats, the need for coordination between the health ministry with other ministries and sectors in finding effective measures to mitigate health security threats.

Whilst the presented case illustrates a health security threat of infectious nature, threats to health security in SADC are diverse. There exists a myriad other threats that could also benefit from SADC health security cooperation. Table 2 outlines some of the health threats that could benefit from deliberate foreign policy interventions by SADC countries and some foreign policy issues with potential to undermine SADC health security but that could positively impact health security if carefully managed.

Table 2: The Interaction between Health Security and Foreign Policy in SADC.

Health Security Threats Affected by Foreign Policy	**Foreign Policy Issues Affecting Health Security**
Lack of access to medicines, vaccines, diagnostics and other essential medical products	Climate change, food security and management of natural resources like water
Weak procurement systems, lack of access to affordable essential medicines	Human mobility, migration of health workers
Poor investment in product development and innovation for neglected tropical and infectious diseases	Global economic and financial crisis
Poor investment in health and weak health systems	Natural disaster, conflict, human rights, civil unrest, post-conflict crisis
Weak national medicines regulatory authorities and the flow of harmful medical products in the national and regional supply chains	Trade in harmful medical products,
Health development goals misaligned with national health security threats and priorities	Negative impact of International trade law and intellectual property laws on access to affordable life-saving medicines and diagnostics, TRIPS-plus conditions

Lack of Access to Essential Medicines

Between 2001 and 2007, 38 percent of medicines on the WHO essential list were available in public and private health facilities in Africa. The problem was more acute for medicines still under patent. The WHO defines essential medicines as those that satisfy the priority health care needs of the entire population. Consequently, many people in SADC die of preventable diseases due to lack of access to affordable essential medicines. Diverse factors undermine the availability and affordability of essential medicines, including weak national medicines regulatory authorities, procurement policies, generics policies and the negative impact of global trade and intellectual property regimes. Therefore, enabling access to essential medicines could be greatly enhanced by international trade regimes and the development and innovation policies that safeguard public health security interests.

The TRIPS agreement has flexibilities to safeguard public health by allowing States to override patents and increase access to medicines in spite of intellectual property under certain public health circumstances.[79] The implementation of TRIPS flexibilities requires national policy and legislative frameworks. This instrument radically altered global supply of affordable medications by countries like India, Brazil, Thailand and South Africa. However, the potential for TRIPS flexibilities to enable access to essential medicines has been undermined by U.S. and EU perception that the flexibilities constitute a political and regulatory impediment to market access. Since the TRIPS agreement, the U.S. has actively pursued and threatened trade sanctions against trade partners who have attempted to implement TRIPS flexibilities, notably South

Africa, Brazil and Thailand. The ability to benefit from TRIPS flexibilities has been further curtailed by U.S. and EU promotion of TRIPS-Plus conditions in bilateral FTAs negotiations which restricts flexibilities implementation across LMICs. Threats of sanctions by the U.S. on countries that utilized TRIPS flexibilities led SADC countries to convene regional meetings to discuss ways of circumventing the negative impact of U.S. foreign policy on access to medicines within SADC.

Such cross-cutting issues require significant foreign policy involvement and intergovernmental negotiations. SADC health security cooperation framework could provide strategies for influencing multilateral negotiations that affect access to safe, efficacious and affordable essential medicines such as the General Agreement on Trade and Services. Through cooperation, SADC could anticipate, prevent and ameliorate the regional health security challenges of access. For example, harmonized procurement systems under the SADC customs union could enhance the bargaining power of countries to negotiate lower prices with pharmaceutical suppliers thereby increasing the availability of safe efficacious and affordable quality essential medicines within countries.

The Threat of Harmful Medical Products

Harmful medical products are another important threat to health security in SADC. These products threaten public health security by, for example, promoting antimicrobial drug resistance which causes treatment failure, toxicity, poisoning, teratogenicity, and may have compounds with contraindications against a person's concurrent medication, which could cause other pathologies, treatment failure due to lack of, insufficient or excessive amounts of active ingredients and even death. SADC also faces a growing threat from uncertified Chinese complementary medicines which claim to be legitimate and certified replacements of pharmaceutical medical products for treating conditions such as hypertension, diabetes and even HIV and AIDS. The World Customs Union reported that 65 percent of global counterfeited medicines originate in China whose export trade in harmful medical products was estimated at $24.6 billion in 2001. Most of these products are destined for Africa. SADC medicines regulatory authorities have been cooperating to stem the transnational supply of harmful medical products by ensuring the affordability of high-quality, safe and efficacious medicines because elevated prices force people to use informal markets for their medicinal needs. Trade in harmful medical products result from organized criminal syndicates, compounded by weak national medicines regulatory authorities, weak legislative frameworks and poor cross-border policing. SADC cooperation could disrupt cross-border supply chains of these harmful medical products.

Harmful medical products are, however, a health security threat of relevance also to other regions such as Europe and Asia. Therefore, African countries could use their health security cooperation frameworks to bridge the division amongst the different positions of the WHO regions that are currently blocking progress on finding a multilateral solution within the WHO to the threat of harmful medical products. Ongoing WHO intergovernmental negotiations on how to address the health security threat of harmful medical products have been impeded by disagreements amongst WHO Member States on the precise nature of these harmful medical products and the manner in which to mitigate their threat to global health security. Protecting health security

requires that the definition does not characterize generic versions of essential medicines under patent but legally manufactured by countries under TRIPS flexibilities as counterfeited medical products. A definition that classifies generics as counterfeit would seriously compromise SADC health security by impeding access to affordable essential. To promote consensus on a definition, SADC could propose the neutral term such as "harmful medical products" as a compromise solution. The determination of harmful medical products would be determined by national medicines legal and policy frameworks informed by WHO guidelines.

Human Mobility, Health Personnel Migration and Weak Health Systems

Functional health systems are the backbone of any credible health security framework. SADC health systems are weakened by a host of factors including health workforce shortages and dependency on foreign aid. Health workers are a key pillar of a functional health system, and the severe shortages in the SADC countries undermine health security. Therefore, regional cooperation to address health workforce shortages would be a critical strategy to improving SADC health systems and its health security. Since health workforce shortages are a global phenomenon, a SADC strategy could promote bilateral and multilateral cooperation frameworks informed by the WHO Global Code. Mutual learning opportunities in the management of health workforce migration are abundant but hardly recognized and utilized. Countries like South Africa have clear policies on managing the employment of foreign health professionals which could be used as a platform for sharing identified good practices in the region.

Food Insecurity and Climate Change

Food is an important determinant of health. Food insecurity causes malnutrition and undermines social stability as was seen with the 2010 food riots in Mozambique as a result of price and supply volatility in the food sector. Some countries in SADC are projected to have food shortages in 2011 due to droughts and flooding which have caused widespread crop failure. Neoliberal policies of the Breton Woods institutions which undermined local food production by reducing subsidies to local farmers and tariffs on imported food in LMICs have also negatively affected local production of food within SADC. High prices of food due to rising inflation and speculation in the commodities markets and the associated increase in import costs has caused food shortages in local markets and food insecurity within countries.

Factors affecting food security undermine social stability and threaten health security. Food insecurity in the SADC context of high HIV prevalence increases risky behavior in vulnerable populations and it affects the ability of people living with HIV and AIDS to take up treatment, stay on treatment, and undermine positive treatment outcomes. Treatment failure due to food insecurity undermines the health security goal of universal access to antiretroviral treatment. SADC health security cooperation strategies could aim to reduce vulnerability to food insecurity through short term social safety nets coupled to long-term livelihoods projects to ensure sustainable solutions to food insecurity that are grounded in the local context.

Climate change, such as increased frequency of droughts and floods, also affects the availability of safe drinking water and food security through, for example,

contamination of underground water sources and crop failure. Climate change has increased the prevalence of vector-borne diseases like malaria and water-borne diseases like cholera. Mitigating the global impact of climate change and food insecurity requires awareness of how climate change affects health security and how to incorporate these concerns in climate change negotiations. SADC health security cooperation could strengthen institutional capacity to pursue long-term development whilst ensuring that health is not marginalized in global trade and climate change regimes.

CONCLUSION

The people-centered approach to global health security justifies the inclusion of all threats that undermine the security of individuals and societies such as lack of access to essential medicines. However, the current global health security agenda is narrowly defined. It excludes threats relevant to African countries these countries with a responsibility to protect the health security of others. Therefore, African countries need consider the potential benefits of participating in shaping the global health security agenda in order to advance their health security interests. African regional cooperation within existing frameworks, such as the SADC, under existing international legal instruments could reduce the cost of participation. The use of health security arguments by countries like the U.S. in multilateral negotiations in attempts to bypass national sovereignty has generated mistrust, and the potential to undermine the faithful implementation of legal instruments such as the IHR(2005). Therefore, a more inclusive health security agenda and greater sensitivity towards health security needs of African countries and other LMICs by the EU and the U.S. during bilateral and multilateral negotiations could restore confidence and enhance international relations and global health cooperation.

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